HOUSE BILL No. 1366

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-4-1; IC 27-13-10-8.

Synopsis: Review of HMO medical determinations. Establishes that an adverse utilization review or medical necessity determination made by a health maintenance organization (HMO) that conflicts with the patient's attending physician's plan of treatment, is an unfair claim settlement practice. Provides for the commissioner of insurance to appoint or contract with a physician for review of adverse utilization review and medical necessity determinations. Requires that HMOs provide notice to enrollees or subscribers of the right to file a complaint with the department of insurance for review of adverse utilization review or medical necessity determinations that conflict with the patient's attending physician's plan of treatment.

Effective: July 1, 1999.

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Goeglein, Fry, Brown C

January 12, 1999, read first time and referred to Committee on Public Health.

Introduced

First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.

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HOUSE BILL No. 1366

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-4-1-4.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 4.5. The following are unfair claim settlement practices:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(6) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become

reasonably clear.

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Attempting to settle claims on the basis of an application which was altered without notice to or knowledge or consent of the insured.

(10) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made.

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(13) Failing to promptly settle claims, where liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(15) In negotiations concerning liability insurance claims, ascribing a percentage of fault to a person seeking to recover from an insured party, in spite of an obvious absence of fault on the part of that person.

(16) The unfair claims settlement practices defined in IC 27-4-1.5.

(17) An adverse:

(A) utilization review determination (as defined in IC 27-8-17-8); or

(B) determination of medical necessity;

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made by a health maintenance organization or an agent of a health maintenance organization that conflicts with the patient's attending physician's plan of treatment.

SECTION 2. IC 27-4-1-5.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: **Sec. 5.7. (a) A complaint filed under section 5.6 of this chapter involving an alleged unfair claims settlement practice under section 4.5(17) of this chapter shall be forwarded to the physician appointed or contracted with under section 15(b) of this chapter.**

(b) The physician shall, within five (5) business days after the complaint is filed:

(1) make a determination of appropriateness of the utilization review determination or determination of medical necessity based on information gathered from the complaining party, the health maintenance organization, the attending physician, and any additional information that the physician considers necessary and appropriate; and

(2) submit the physician's findings to the commissioner.

If the physician needs additional time to investigate before submitting findings to the commissioner, the physician shall advise the commissioner of the need for additional time.

(c) The commissioner shall consider the physician's findings in any action taken by the commissioner on a complaint filed under section 5.6 of this chapter involving an alleged unfair claims settlement practice under section 4.5(17) of this chapter.

SECTION 3. IC 27-4-1-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 15. (a) For the purpose of maintaining the affirmative, active, and definite administration of the provisions of this chapter, the commissioner, with the approval of the governor, may appoint such additional actuaries, agents, deputies, examiners, assistants, stenographers, reporters, and other employees in the department as may be found necessary to carry out the provisions of this chapter. Except as otherwise provided in this chapter, such additional deputies, examiners, assistants, reporters, and employees so appointed shall be chosen for their fitness, either professional or practical, as the nature of the position may require, irrespective of their political beliefs or affiliations. The technical or professional qualifications of any applicant shall be determined by examination, professional rating, or otherwise, as the commissioner with the approval of the governor may determine. Subject to the approval of the governor and the state budget director, the salaries of such additional

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actuaries, agents, deputies, examiners, assistants, stenographers, reporters, and other employees shall be fixed by the commissioner. Any actuary agent, deputy, examiner, assistant, stenographer, or employee so employed may be removed at any time by the commissioner.

(b) The commissioner shall appoint or enter into a contract for services with a physician licensed under IC 25-22.5 for all complaints filed under section 5.6 of this chapter regarding alleged unfair claims settlement practices under section 4.5(17) of this chapter.

~~(b)~~ **(c)** In the absence of the commissioner, he may, by written order, designate a deputy to conduct any hearing, and, in such case, such deputy commissioner shall possess and may exercise all powers of the commissioner with respect to the matter in hearing.

~~(c)~~ **(d)** Neither the commissioner nor any actuary, deputy, examiner, assistant, or employee in the department shall be liable in their individual capacity, except to the state of Indiana, for any act done or omitted in connection with the performance of their respective duties under the provisions of this chapter.

SECTION 4. IC 27-13-10-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 8. (a) A health maintenance organization shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(1) Acknowledgment of the appeal, orally or in writing, within three (3) business days after receipt of the appeal being filed.

(2) Documentation of the substance of the appeal and the actions taken.

(3) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(4) Notification to enrollees or subscribers of the disposition of the appeal and that the enrollee or subscriber may have the right to further remedies allowed by law.

(5) Standards for timeliness in responding to appeals and providing notice to enrollees or subscribers of the disposition of the appeal and the right to initiate an external appeals process that accommodate the clinical urgency of the situation.

(b) The health maintenance organization shall appoint a panel of qualified individuals to resolve an appeal. An individual may not be appointed to the panel who has been involved in the matter giving rise to the complaint or in the initial investigation of the complaint. Except for grievances that have previously been appealed under IC 27-8-17, in

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the case of an appeal from the proposal, refusal, or delivery of a health care procedure, treatment, or service, the health maintenance organization shall appoint one (1) or more individuals to the panel to resolve the appeal. The panel must include one (1) or more individuals who:

(1) have knowledge in the medical condition, procedure, or treatment at issue;

(2) are in the same licensed profession as the provider who proposed, refused, or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or the previous grievance process; and

(4) do not have a direct business relationship with the enrollee or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved as expeditiously as possible and with regard to the clinical urgency of the appeal. However, an appeal must be resolved not later than forty-five (45) days after the appeal is filed.

(d) A health maintenance organization shall allow enrollees and subscribers the opportunity to appear in person at the panel or to communicate with the panel through appropriate other means if the enrollee or subscriber is unable to appear in person.

(e) A health maintenance organization shall notify the enrollee or subscriber in writing of the resolution of the appeal of a grievance within five (5) business days after completing the investigation. The grievance resolution notice must contain the following:

(1) The decision reached by the health maintenance organization.

(2) The reasons, policies, or procedures that are the basis of the decision.

(3) Notice of the enrollee's or subscriber's right to further remedies allowed by law.

(4) The department, address, and telephone number through which an enrollee may contact a qualified representative to obtain more information about the decision or the right to an appeal.

(f) The notice required under subsection (e)(3) for a grievance that involves an adverse utilization review determination or adverse determination of medical necessity must include notice of the enrollee's or subscriber's right to file a complaint with the department under IC 27-4-1-4.5(17).

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